VISTA®CARE CAREGIVER INFORMATION AND REGISTRATION FORM

PLEASE PRINT CLEARLY !!!!THIS SIDE TO BE COMPLETED BY CAREGIVER ONLY!!!!

Caregiver's Name (As it will appear on checks and on coupons): Date of Birth _____/_____/_____

Caregiver's Mailing Address:

_____

_____

Address where care is to be provided:

_____

_____

What county is this address in: _____

What is your telephone number? (_____)_____-_____

YOU MUST COMPLETE THIS SECTION:

SSN # (if you are unlicensed/unregulated): _____-_____-_____ **(ATTACH A COPY OF SOCIAL SECURITY CARD)**

OR Fed ID # _____-_____-_____ **(ATTACH A COPY OF LICENSE OR REGISTRATION)**

Check as appropriate: Type of Care: FDC (Family Day Care Home) _____ Center_____
Group Home_____ Unlicensed/Unregulated_____

Regulatory Status: Licensed/Regulated _____ Exempt (i.e. family member, friend) **_____

Child Care License No./Registration No. (If applicable): _____
Licensing Contact Name and Phone Number: _____ (_____)_____-_____

**YOU MUST MEET STATE GUIDELINES TO BE CONSIDERED LEGALLY EXEMPT; contact VISTA®CARE or your state licensing agency for more information.

Date Care Begins:_____/_____/_____ **Date Care Ended (if applicable):** _____/_____/_____

VISTA Member's Name: _____

NAMES OF CHILDREN TO BE CARED FOR THROUGH VISTA®CARE

Member's Child(ren) In Your Care	SSN (must be filled in)	Date of Birth	Gender (M/F)	Relationship to Caregiver
1.	- -			
2.	- -			
3.	- -			
4.	- -			

Member's Child(ren) In Your Care	Period of Care (✓) SUN	MON	TUE	WED	THU	FRI	SAT	Hours Children In Care From	To
1.									
2.									
3.									
4.									

To be completed by Family Day Care Homes, Group Day Care Homes, and Unlicensed/Unregulated Individuals Only: Please list the total number of children in your care and relationship to you, if applicable. Total # of Children in Your Care: _____

Child: **Relationship:**

_____ _____

_____ _____

_____ _____

VISTA®CARE Caregiver Information Registration Form (cont.)

CAREGIVER RESPONSIBILITIES AND CERTIFICATION

1. Caregiver will continue to meet all minimum requirements set by the state and agrees to comply with all VISTA®CARE policies necessary for reimbursement.
2. Caregiver will notify VISTA®CARE immediately when a child ceases to receive care. It is understood that any parent must be given access to his/her child(ren) at any time during care hours.
3. Caregiver will mail the monthly coupon/attendance sheet **NO LATER THAN the first (1st) day** of the month following care or upon termination of care (if care stops before the end of the month). **PLEASE NOTE:** Reimbursement may be delayed if the childcare coupon is postmarked later than the 1st day of the month following care. In addition, 24-hour or overnight care **may not** be legal in all states.
4. Caregiver will not charge a higher fee for children of VISTA Members than for the same service to the public. **NOTE: Failure to adhere to this policy will result in caregiver being required to refund overpayments and in cancellation of this and future payments from VISTA®CARE.**
5. **VISTA®CARE** will not pay additional fees for registration, late, transportation, meals, snacks, trips (ie., fieldtrips, etc.) or any other miscellaneous fees. Caregiver shall collect any such fees directly from the Member.
6. Caregiver agrees to repay **VISTA®CARE** any money received for which services were not provided.
7. Caregiver agrees to notify **VISTA®CARE** at least fifteen (15) calendar days before ending childcare services. **NOTE: In cases of emergency please notify VISTA®CARE immediately (1.800.793.0324).**
8. **VISTA®CARE** has a maximum reimbursement of $300.00 per month, per VISTA member.

The VISTA Member has chosen you to provide childcare services. Prior to reimbursement, you must first provide all information requested on the front of this form, be determined a legal caregiver in your state, and the member must be determined and remain eligible to receive childcare benefits through **VISTA®CARE**.

_____ _____/_____/_____

Caregiver Signature Date

VISTA®CARE RESPONSIBILITIES

1. VISTA®CARE is responsible for coordination of childcare allowance and other related support services as necessary to the children and families served under this agreement.
2. VISTA®CARE will pay only pay **licensed and regulated** caregivers for federal holidays and school vacations. VISTA®CARE will also pay **licensed and regulated caregivers** for up to five sick/no-care days per month. Excessive absences may require formal documentation (ie., doctor's note).
3. VISTA®CARE will not pay more than one caregiver, for the same child(ren), for the same period of care.

PARENT RESPONSIBILITIES AND CERTIFICATION

I [the member] understand that:

1. Childcare benefits for which I am eligible are based on my income, family size, age of child(ren), the caregiver's location, and the type of child care I select and that if there are any changes to my situation**, I must make both my State Program Officer and VISTA®CARE aware of those changes**.
2. I agree to complete the necessary documents (ie., childcare coupons) on a timely basis, to ensure the caregiver may receive timely reimbursement.
3. I agree to submit proof of my continued eligibility for this program when requested.
4. I agree to notify VISTA®CARE at least fifteen (15) calendar days before ending childcare services. In cases of emergency please notify VISTA®CARE immediately (1.800.793.0324).
5. I understand that the caregiver indicated on page 1 of this form must meet all state requirements to provide childcare services, and that VISTA®CARE is under no obligation to begin reimbursements before the caregiver has been determined legal.

I have read this agreement and understand that failure to comply with the terms of this agreement may result in the termination of my childcare benefits.

_____ _____/_____/_____

VISTA Member Signature **Date**

!!!!MEMBER: PLEASE FORWARD THIS AND ALL CHILDCARE FORMS TO YOUR STATE PROGRAM OFFICER FOR SIGNATURES!!!!

STATE PROGRAM OFFICER CERTIFICATION

I certify that the Member requiring childcare services as per this agreement is a full-time VISTA Member and is eligible for childcare benefits through VISTA®CARE. I authorize that funds designated for childcare be made available to VISTA®CARE for regular payment of services as described above.

_____

State Program Officer's Name

_____ _____/_____/_____

State Program Officer's Signature **Date**